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MEMORANDUM

TO: Area Directors

FROM: Mike Moseley, Director, DMH/DD/SAS
Gary Fuquay, Director, DMA

SUBJECT: Update

DATE: May 4, 2004

Staff from our two Divisions have been working on a variety of issues related to the reform of our public mental health, developmental disabilities and substance abuse services system. Their work has involved input from the N.C. Council of Community Programs (Council) and the N.C. Association of County Commissioners (NCACC). The purpose of this joint memorandum is to update you on the status of several key issues which are currently under development or consideration.

Direct Enrollment of Independent Practitioners

As you know, certain types of independent practitioners (IPs) currently may directly enroll in the Medicaid program through the Division of Medical Assistance (DMA) to provide outpatient therapy to Medicaid-eligible children. Those same professionals may not currently serve adults. In addition, other categories of independent practitioners have requested the ability to directly enroll with the Medicaid program for a number of years. These providers offer outpatient therapy services which have been categorized as part of the Basic Benefit in the mental health, developmental disabilities and substance abuse services system reform process.

DMA, with agreement from DMH/DD/SAS, has decided to ensure parity within licensure categories of independent practitioners by allowing enrolled IPs who may currently directly enroll to serve children to do so for services to adults. In addition, DMA is currently formulating plans for enrolling additional categories of IPs to include: Licensed Psychological Associates (LPA), Licensed Professional Counselors (LPC), Licensed Marriage & Family Therapists (LMFT), Certified Clinical Supervisors (CCS, SA), and Certified Clinical Addictions Specialists (CCAS). All IPs will bill using CPT codes. DMA anticipates an October 1, 2004 effective date. We are currently working with the General Assembly to include special provision language addressing this as well as preparing the Medicaid State Plan Amendment for submission to CMS.

Cost Settlement of Local Management Entity System Management Functions

The DMH/DD/SAS, DMA and the Office of the DHHS Controller have agreed to develop a cost allocation methodology to accurately allocate the cost of the LME System Management payments between Medicaid

and State funds. Medicaid limits payments to governmental entities to actual cost. Therefore, the LME System Management payments will have to be settled to cost in terms of the Medicaid portion of the payment. We are continuing to work together, and with the DHHS Office of the Controller, to finalize the processes and procedures that will be used to ensure compliance with this requirement. At this point, we plan to establish a routine monthly reporting requirement through which each LME will detail the actual cost incurred, broken down by certain cost categories and staff credentials, during the previous month. The Office of the DHHS Controller will use the reports to allocate the total cost incurred between state and Medicaid funds and draw the Medicaid funds into the DMH/DD/SAS budget. At year-end, a comparison of the actual costs reported in each LME's independent audit will take place to ensure that all costs were reported correctly and allocated appropriately during the fiscal year. We will publish additional guidance on this issue as soon as the remaining details have been finalized between the three Divisions.

DHHS/LME Contract

We have begun and are progressing toward completion of the statewide negotiation on the DHHS/LME contract with the public partners as outlined in Communications Bulletin 15. DHHS is represented by a team from DMH/DD/SAS, DMA and the Office of the Controller. The NCACC's negotiating team is comprised of two county attorneys and one area program attorney while four Area Directors serve as the negotiators for the Council.

The "look" of the contract has changed significantly through the negotiations thus far. Both the NCACC and the Council felt very strongly that the Local Business Plans (LBPs) should serve as the Scope of Work for the Contract. The Council and the NCACC correctly pointed out that the reform legislation mandated the creation of the LBPs and communities had spent a great deal of time working on them. DHHS understood and acknowledged the validity of that argument, but also noted that a number of requirements that must be included in the contract, such as "prompt pay" language and Medicaid requirements regarding consumer freedom of choice were not contained in most LBPs. In addition, the LBPs are not currently in a standardized format, so it is difficult for the DMA and Office of the Controller to review them to ensure that all requirements have been addressed. As a compromise, we have agreed that the LBP will become Attachment I, Scope of Work, to the contract. There will also be an Attachment II, Statewide Requirements, which will outline those issues that must be addressed on a consistent, statewide basis. The base contract document stipulates that in case of a conflict between the LBP and the Statewide Requirements, the Statewide Requirements will prevail. As soon as revised versions of the base contract document and the new Attachment II have been reviewed and approved by negotiators and the Office of the Attorney General, we will post them to the DMH/DD/SAS website for your review and input. .

Another point of negotiation and agreement during our discussions with the Council and NCACC was that the contract should only cover those items that are required for SFY 2004-2005. We agreed that other items in the contract are more developmental in nature. The developmental items will be added to the contract via amendment or update in future periods. In addition, we have agreed that it is too confusing to try to address the service delivery system as it will be on July 1, 2004 and the service delivery system as we believe it will be when the new service definitions are approved. Therefore, the contract as now written only addresses the system under which we will operate as of July 1, 2004. As soon as this first round of negotiations is completed, we will begin work on an amendment to be effective when the new service definitions are approved and implemented.

A final agreement is that, as a legally binding agreement, the contract will not contain the policy guidance issues that were envisioned to be part of the original Attachment III, such as the proposed CFAC/LME Relational Agreement, the Person Centered Planning guidelines, etc. Those types of policy guidance documents will be issued through a numbered communication series of DHHS/LME Contract correspondence.

The next steps for the negotiators is to finalize the performance expectations that will now be outlined in a new Attachment III and any modifications that may be necessary to Attachment IV, the funding component of the contract. We have scheduled two additional meetings in May to finalize those matters. Once those issues are finalized and the revised contract and all attachments have been reviewed and approved by the Office of the Attorney General, we will be ready to enter into a contract with each individual LME.

Service Definitions

The DMA and DMH/DD/SAS have reached tentative agreement on the service definitions for new services to be included under the Rehabilitation Option in the Medicaid State Plan. We expect to soon reach final agreements on rates and provider qualifications. We anticipate that those activities will be completed by June. At that time, the definitions must be submitted to the Mental Health Committee of the Physician's Advisory Group (PAG) for review. The General Assembly, through a Special Provision in the Appropriations Act, requires DMA to consult with the PAG on all issues of medical policy coverage (HB 397 Section 10.19(bb)). We do not know how much time the PAG subcommittee will need to review the package, or how quickly their recommendations can be processed by the full PAG. Once the PAG process and required fiscal analysis have been completed, DMA will be able to submit the State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) for review. At the same time, the Medicaid policies must be published for a mandated 45-day public comment period. Our goal continues to be to have the SPA approved by January 1, 2005. In recognition of the significant transition and implementation issues that will have to be addressed, we are now planning for an implementation date of July 1, 2005. We will work with you to develop the transition and implementation plans, with input from consumers, providers and other stakeholders, during the first quarter of SFY 2004-2005.

Service Rates

We recognize the difficulty of planning next year's budget and continuing divestiture and provider development efforts without knowing the rates that will be paid for services. We are very close to finalizing the rates for the existing service array and we hope to be able to publish those rates within the next two weeks. They will be based upon the SFY 2002 actual cost finding.

The rates for the new enhanced service definitions are also under review. We are waiting for final utilization projections from our consultants in order to project the impact upon the Medicaid budget of the new service definitions and proposed rates. Once that information has been received and reviewed we will finalize our rate discussions and publish the rates for review and comment by all stakeholders, LMEs, providers, and consumers As part of this process we plan to meet with a cross-section of providers to receive feedback on the rates. Our goal is to complete this process no later than the end of November, 2004.

Direct Enrollment of Enhanced Benefit Service Providers with Medicaid

In a letter dated October 22, 2003 from Rich Visingardi and Gary Fuquay, our divisions outlined our intent not to expand the types of providers of enhanced benefits that could be directly enrolled in the Medicaid program through the Division of Medical Assistance. Since that communication, however, we have had several interactions with CMS which have required us to reconsider that position.

Medicaid regulations at 42CFR431.107 require "an agreement between the Medicaid agency and each provider or organization furnishing services under the plan." CMS has indicated that, in accordance with this regulation, all providers receiving Medicaid payments for covered services must be directly enrolled with DMA. The only way to restrict the ability of providers to directly enroll and bill Medicaid would be through a 1915(b) waiver. The complexity of the waiver process eliminates that as an option at this time.

DHHS is committed to ensuring a strong role for the LMEs. One of the major tenets of reform is the recognition of the need to have a manager at the local level that is responsible for coordination and ensuring

the adequacy and quality of the delivery of services. We are developing provider enrollment procedures that will require providers of enhanced benefit services to be endorsed by the LME prior to Medicaid enrollment and to be periodically re-endorsed by the LME in order to continue as qualified Medicaid providers. We believe that this endorsement and re-endorsement, coupled with the LME's role in authorizing services based upon a Person Centered Plan, will provide the LMEs with the authority necessary to fulfill their role as local public managers of the service delivery system. We are currently working through the details of the provider qualification and the provider certification. We will involve the Council and the NCACC in those discussions.

Utilization Review

As you know, ValueOptions is currently under contract to DMA to perform utilization review (UR) functions for a number of MH/SA services. That contract expires on December 31, 2004. Although our Divisions are discussing responsibility for UR functions for MH/DD/SA services, the processes and procedures have not been determined. In order to ensure coverage effective January 1, 2005, DMA must issue a RFP this summer to secure a contractor to perform, at minimum, the functions ValueOptions currently performs.

Considerations in determining LMEs' readiness to perform UR are the need for statewide consistency and ability to perform the same prior authorization functions as a UR vendor. As you know, without a waiver of certain components of the Social Security Act, Medicaid regulations require services, processes, procedures, etc. related to Medicaid eligible persons and Medicaid covered services to be uniform across the state. This means that there must be consistency statewide in terms of the procedures, processes and outcomes of UR vendors, including potentially from one LME to another.

We also recognize that the intensity of the UR processes and procedures should be directly related to the cost and utilization of the service. DMA and DMH/DD/SAS are currently reviewing all of the current and proposed service definitions to determine the level of UR that will be applied to each service. For example, for very high end services such as inpatient hospitalizations, a prior authorization (PA) must be entered into the Medicaid management information system (i.e., EDS). For others, such as outpatient therapy, a certain number of units of service may be delivered before a PA is ever required, as is currently the situation.

Once we have agreed to the level of UR that each service requires, we will identify and publish the processes and procedures that must be followed for those services requiring UR activity. We will then follow-up with the development of readiness criteria that will be used to evaluate each LME's ability to perform UR functions with the required degree of statewide consistency. The RFP that DMA issues in the summer to secure a vendor for utilization review will include all of the services for which we determine a prior authorization into the Medicaid management information system is required. We also plan to have the new statewide vendor perform post-payment (a "look behind") and quality review for all UR

Provider Community

We continue to receive complaints that LMEs are attempting to limit or stratify the number of providers in their provider networks. Again, for Medicaid eligible consumers, freedom of choice of provider cannot be limited in any way, without approval from CMS. All directly enrolled independent practitioners are automatically deemed to be a part of the LMEs community of providers for services to Medicaid consumers. [Note: we're no longer using the term "qualified provider network," since that term carries managed care connotations related to limited networks, limiting consumer choice, etc.] If they wish to receive referrals from the LME or serve non-Medicaid eligible consumers and receive payment from the LME, they must enter into an abbreviated Memorandum of Agreement with the LME. All other directly enrolled qualified Medicaid providers must be offered a contract to join the LME's community of providers. LMEs cannot limit the number of providers available to consumers, nor group providers into "preferred providers" and "others." A Medicaid eligible consumer must be free to choose any qualified Medicaid provider if they meet

medical necessity criteria for the services offered by the provider. As DMH/DD/SAS and DMA continue to discuss these issues, further guidance will be issued.

We know that many important matters are not yet final. Please know that we our committed to continuing to work diligently to resolve those issues and to communicate with you frequently regarding decisions. To further help with communication, we are pleased that the N.C. Council of Community Programs has agreed to allow our Divisions to meet Area Directors face-to-face during a portion of the monthly Area Director's Forum to discuss pending issues.

Please contact either of us, Leza Wainwright in DMH/DD/SAS, or Barbara Brooks in DMA, if you have questions.

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